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12852

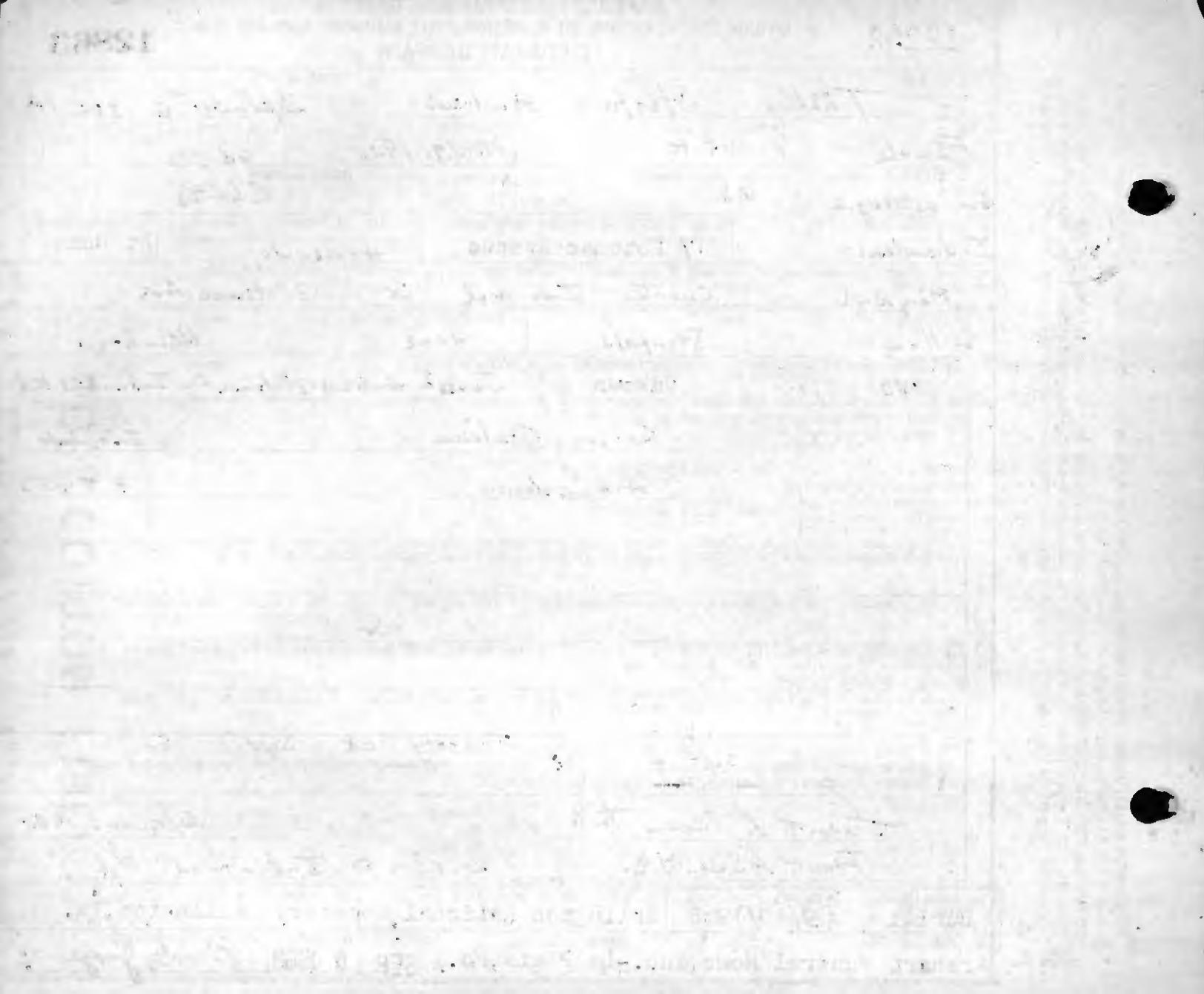
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12863

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Thelma</i>	Middle <i>Starfield</i>	Last <i>Andrews</i>	2a. DATE OF DEATH Month <i>September</i>	Day <i>6</i>	Year <i>1968</i>	2b. HOUR <i>1A M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>March 7, 1900</i>		6. AGE (In years last birthday) <i>68</i>		IF UNDER 1 YEAR MONTHS <i>68</i>	IF UNDER 24 HRS. DAYS <i>00</i>
7a. BIRTHPLACE (State or foreign country) <i>America Georgia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Charles</i>	
10. CITY OR TOWN OF DEATH <i>Indian Head</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>17 Potomac Avenue</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Charles</i>		13c. CITY OR TOWN <i>Indian Head</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>17 Potomac Ave</i>
14. FATHER'S NAME First <i>William</i>		Middle <i>Starfield</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Jane</i>		Middle <i>Hembrow</i>	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>James E Andrews 17 Potomac Ave Indian Head Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>4109</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerosis</i>				4-5 years	
(b)		DUE TO, OR AS A CONSEQUENCE OF <i></i>					
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 4, 1968</i> , to <i>Sept. 6, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept. 4, 1968</i> , and that in my (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Frank A Susan D</i>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Rt. 1 Box 50, Indian Head, Md.</i>		22c. DATE SIGNED <i>September 6, 1968</i>			
23a. BURIAL, CREMATION, BENEFICIAL (Specify) <i>Burial</i>		23b. DATE <i>9/10/1968</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National Cemetery</i>		23d. LOCATION (City or Town), (County) (State) <i>Arlington, Va.</i>	
24. FUNERAL DIRECTOR <i>Arehart Funeral Home, Inc.-La Plata, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>SEP 10 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

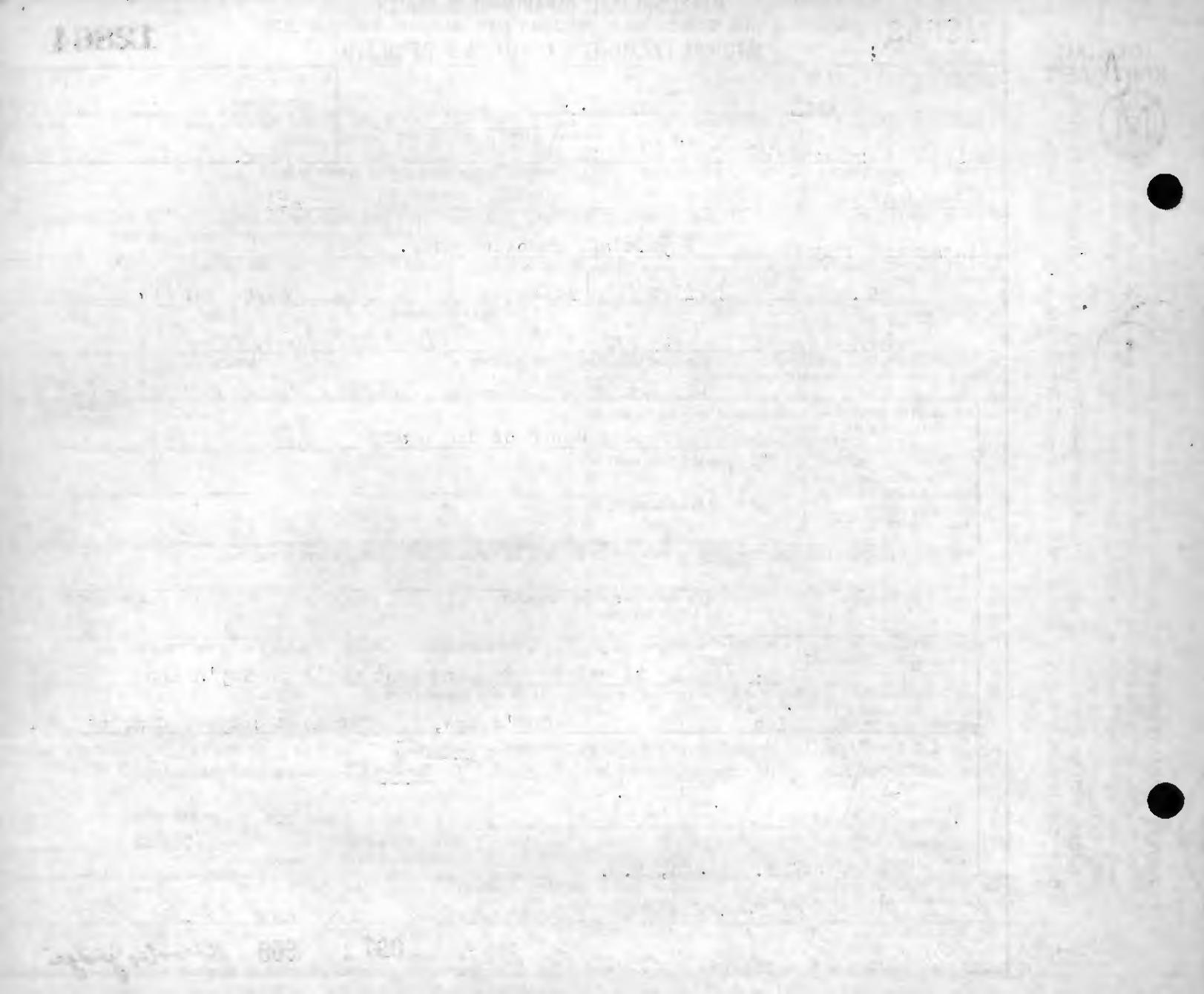
12853

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12864

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR		
			EARL	LEONARD	BROWN	9	21	19	68	11 p.m.		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years lost birthday)			IF UNDER 1 YEAR	IF UNDER 24 HRS					
Male	Colored	Nov. 4, 1939	28	YRS.	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. COUNTY OF DEATH	
Pr. Geo. Co. Md.		U.S.A.									Charles	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Patauxent City			Physicians Memorial Hosp.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Md.		Charles P.G.		Aquasco		YES <input type="checkbox"/> NO <input type="checkbox"/>		Aquasco, Md.				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Columbus				Brown		Alberta			Pinkney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
(If yes give war or dates of service)			217-36-5245			Columbus Brown Aquasco, Md. 20608						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of the heart DUE TO, OR AS A CONSEQUENCE OF 965X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 981X												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 9:50 P.M. 9 21 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Subject shot while in Toy's Inn						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Inn			21f. LOCATION Street or R.F.D. No. City or Town County State Toy's Inn, Patuxent City Charles Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> Signature: Edward F. Wilson, M.D.												
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 9/23/68
ADDRESS (Street, city, town, or county) Edward F. Wilson, M.D.												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town) (County) (State)			
Burial			Sept. 26/68			John Wesley Ch. Cem.			Aquasco, Pr. Geo. Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Martell Adams Aquasco, Md.						OCT 1 1968			Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201,

12865

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>EVA</i>	Middle <i>JANE</i>	Last <i>DAVIS</i>	2a. DATE OF DEATH Month <i>9</i>	2b. HOUR 140 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 1, 1888		6. AGE (In years at birthday) 80	IF UNDER 1 YEAR MONTHS YRS.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Charles	12b. KIND OF BUSINESS OR INDUSTRY At Home
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial Hospital H/W			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) H/W	12b. KIND OF BUSINESS OR INDUSTRY At Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Charles	13c. CITY OR TOWN Marbury	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER	
14. FATHER'S NAME First George W. Henderson	Middle Last	15. MOTHER'S MAIDEN NAME First Kate Norman	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. Unkown	17. INFORMANT Miss. Frances Davis-Daughter-Marbury, Md	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 796.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Mesentecitis, Peritonitis DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-6-68 to 9-7-68		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7950					
19a. MEDICAL CERTIFICATION DATE OF OPERATION 7/7/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING □ CAUSE OF DEATH If either, notify medical examiner	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While □ Not while □ at work □ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9-6-68 to 9-7-68 that (I) (we) last saw the deceased alive on 9-6-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>E.J. Edelen MD</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9/7/1968	
22d. PHYSICIAN'S NAME (Type) E.J. Edelen, M.D.	22e. ADDRESS La Plata, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/9/1968	23c. NAME OF CEMETERY OR CREMATORIAL Nanjemoy Baptist Cemetery	23d. LOCATION (City or Town) Nanjemoy, Maryland	(County)	(State)
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE SEP 10 1968	

27881



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12855

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12866

1. DECEASED-NAME (Type or Print)	First <i>Wills</i>	Middle <i>KERNIEL</i>	Last <i>DORSEY</i>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 9	Day 28	Year 1968	2b. HOUR 158 p.m.			
3. SEX <input checked="" type="checkbox"/> M	4. RACE <input checked="" type="checkbox"/> N	5. DATE OF BIRTH <i>July 1, 1950</i>	6. AGE (In years last birthday) <i>18 yrs</i>	IF UNDER 1 YEAR MONTHS <input type="checkbox"/>	IF UNDER 24 HRS DAYS <input type="checkbox"/>	HOURS <input type="checkbox"/>	MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month 9	Day 28	Year 1968	2d. HOUR 3 p.m.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Charles</i>								
10. CITY OR TOWN OF DEATH <i>Faulkner Md</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farming</i>	12b. KIND OF BUSINESS OR INDUSTRY <input type="checkbox"/>								
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Charles</i>	13c. CITY OR TOWN <i>Newburg</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>Newburg, Md.</i>							
14. FATHER'S NAME First <i>Joseph</i>	Middle <i>P.</i>	Last <i>Dorsey</i>	15. MOTHER'S MAIDEN NAME First <i>Katherine Inez</i>	Middle <i>Dorsey (Edelen)</i>	Last <i></i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>218-56-7126</i>	17. INFORMANT <i>Katherine I. Dorsey, Rt. 1, Box 160,</i>	ADDRESS <i>Newburg, Md.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>955 X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <input type="checkbox"/>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>176 X</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>158 p.m.</i>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>9.28 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>shot self in head after shooting boyfriend</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>farm</i>	21f. LOCATION Street or R.F.D. No. <i>Faulkner</i>	City or Town <i>Charles</i>	County <i>Md</i>	State <i></i>						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						22b. DATE SIGNED <i>9.29.68</i>					
ACTUAL SIGNATURE <i>Werner N. Spitz</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county) <i>Issue, Charles, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Oct. 1, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Ghost Cemetery</i>	23d. LOCATION (City or Town) <i>Issue, Charles, Maryland</i>	(County) <i></i>	(State) <i></i>						
24. FUNERAL DIRECTOR <i>Arehart Funeral Home Inc., La Plata, Md.</i>	ADDRESS	25a. RECD BY REGISTRAR DATE <i>OCT 3 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

best

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12856 Item 5 Form 501-176-14

12867

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First <i>Catherine</i>	Middle <i>J</i>	Last <i>FORD</i>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month <i>9</i>	Day <i>28</i>	Year <i>1968</i>	2b. HOUR <i>1:55 P.M.</i>			
3. SEX <i>F</i>	4 RACE <i>N</i>	S. DATE OF BIRTH <i>5-6-54</i>	6. AGE (In years last birthday) <i>15 yrs</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>9</i>	Day <i>28</i>	Year <i>1968</i>	2d. HOUR <i>3:00 P.M.</i>
7a. BIRTHPLACE (State or foreign country) <i>Charles County</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <i>Charles</i>								
10. CITY OR TOWN OF DEATH <i>Faulkner Md</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Physicians Memorial Hosp</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Charles</i>	13c. CITY OR TOWN <i>Faulkner</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>None</i>							
14. FATHER'S NAME First <i>James</i>	Middle <i>J.</i>	Last <i>Ford</i>	15. MOTHER'S MAIDEN NAME First <i>MARY</i>	Middle <i>J</i>	Last <i>Thomas</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>—</i>	17. INFORMANT <i>MARY J. Thomas</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>965x</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Multiple Gunshot Wounds</i>	ADDRESS <i>Faulkner, Md</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>None</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>981X</i>											
19a. DATE OF OPERATION <i>981X</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>Shot by boy friend who then shot self</i>	21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>1:55 P.M.</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Shot by boy friend who then shot self</i>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>	21f. LOCATION Street or R.R. No. City or Town County State <i>Faulkner Charles Md</i>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Werner U. Spitz</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED <i>9.29.68</i>						
EXAMINER'S NAME (Type) <i>WERNER U. SPITZ</i>	ADDRESS (Street, city, town, or county) <i>None</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Oct. 2, 1968</i>	23b. DATE <i>Burial</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Sacred Heart Cemetery-La Plata, Charles, Md.</i>	23d. LOCATION (City or Town) (County) (State) <i>Charles, Md.</i>								
24. FUNERAL DIRECTOR <i>Leroy E Berry</i>	25a. REC'D BY REGISTRAR <i>Oct 9 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

19881



2000

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

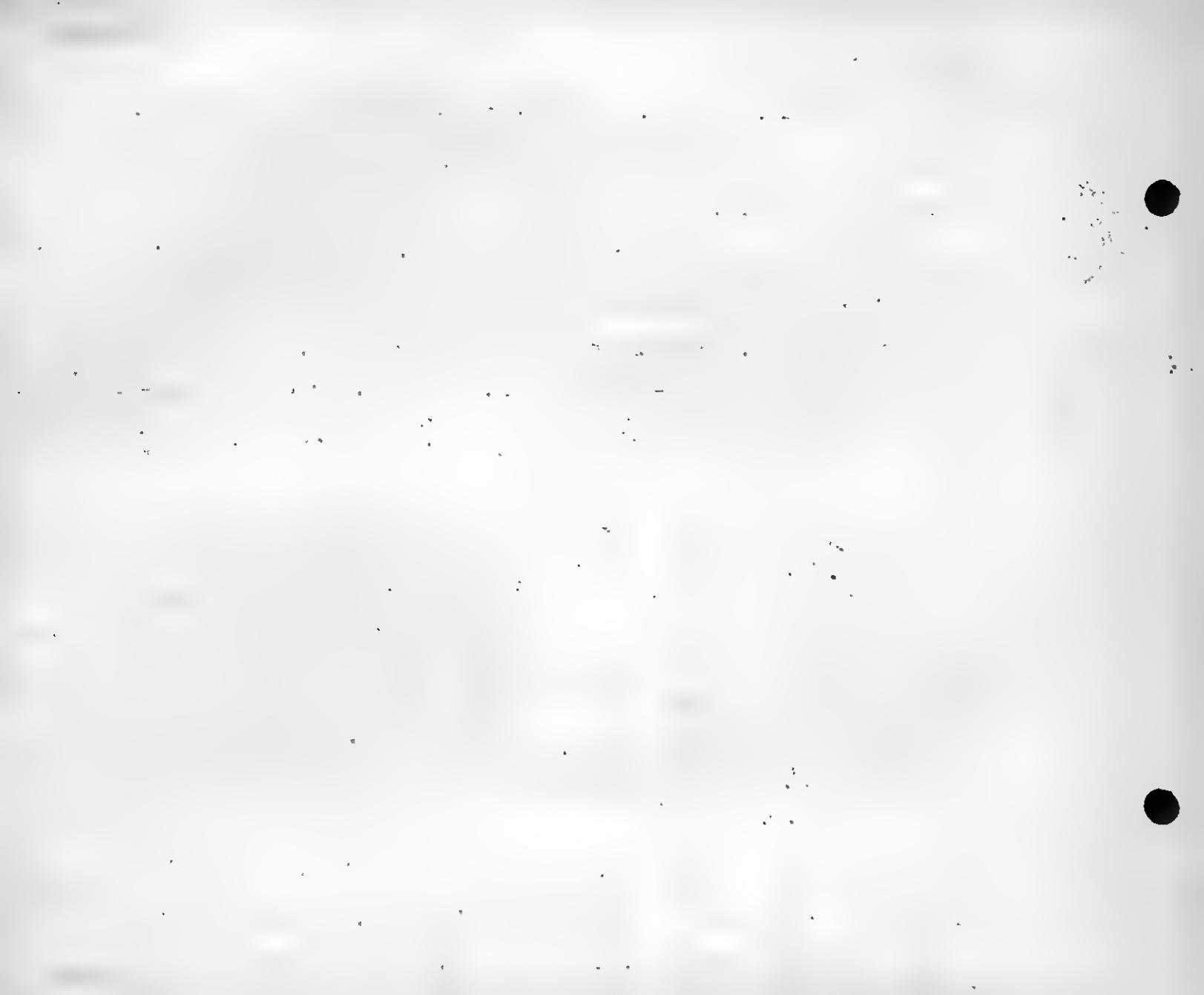
12868

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours from death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First HERBERT	Middle P.	Last HENDERSON	2a. DATE OF DEATH Month 9 Day 15 Year 68	2b. HOUR 11:30 AM
3. SEX Male	4 RACE White	5. DATE OF BIRTH Feb. 12, 1903		6. AGE (in years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 4 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Charles		
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Conductor	12b. KIND OF BUSINESS OR INDUSTRY Capital Trans	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Charles	13c. CITY OR TOWN Nanjemoy	13d. INSIDE CITY LIMIT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rural	
14. FATHER'S NAME Charles H. Henderson	15. MOTHER'S MAIDEN NAME Mary F. Knapp				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 578-10-7124	17. INFORMANT Mr. Alton V. Henderson-Son-Nanjemoy,	Address Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause lost (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-15-68					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Secondary Pulmonary					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this Hospital) attended the deceased from 9-11-68 to 9-15-68 , that (I) (we) last saw the deceased alive on 9-15-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Edelen	DEGREE ATTENDING PHYS.	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-15-68	
22d. PHYSICIAN'S NAME (Type) E.J. Edelen, M.D.	22e. ADDRESS La Plata, Maryland				
23a. BURIAL, CREMATION, REMAINS SENT	23b. DATE 9/17/1968	23c. NAME OF CEMETERY OR CREMATORIUM Nanjemoy Baptist Cem.	23d. LOCATION (City or Town) Nanjemoy, Maryland	(County)	(State)
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.	ADDRESS Arehart Funeral Home, Inc.-La Plata, Md.	25a. RECD BY REGISTRAR SEP 18 1968	25b. REGISTRAR'S SIGNATURE Charles Jugee		



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.
Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death
necesary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.
5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15M (5)
10M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 23c, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 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607, 608, 609, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 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1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1400, 1401, 1402, 14



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in Part 1 Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm plan. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												12870
1. DECEASED NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF ESTI. DEATH MATED			Month	Day	Year	2b. HOUR
JILL Melannie KISNER						<input type="checkbox"/> <input checked="" type="checkbox"/>			09	17	1968	10 AM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years at birthdate) 5 yrs.			IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR	
F	Cau.	Dec. 12 1962				MONTHS	DAYS	HOURS	MN	Month	Day	Year
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			
Wash. D.C.			U.S.A.						Charles			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
La Plata			Physicians Memorial									
13a. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER			
Md.			Chas.			Hughesville			Hughesville Manor			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost	
Lonnie Lee Kisner			Jr	Betty		Carol			Sullivan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
—			—			Mrs. Betty C. Kisner			Hughesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Pneumonia - Community type of disease passenger												9-18-68
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
2164			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?			
19c. MEDICAL CERTIFICATION			19d. TIME OF INJURY Month, Day, Year HOUR A.M. 10:00 PM 9-13 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) A car head on accident			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Nancy			21f. LOCATION Street or R.F.D. No City or Town County State						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. P. PLACE OF N. INJURY (At home, farm, street, factory, office building, etc.) Nancy			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			E. E. KISNER			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 9-13-68			
EXAMINER'S NAME (Type)						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE 1-2-68			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City or Town) Baltimore			
24. FUNERAL DIRECTOR									(County) (State)			
VR A15ME (S) 10M REV 1/68						25a. REC'D BY REGISTRAR DATE SEP 20 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.~~AA~~

Any delays in filing this report will result in a fine of \$50.00 per day.

PM3 Page 1, 2, and 3

The Chief Medical Examiner's Office along with form

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of

Health prior to burial, cremation, or removal and in any event within 72 hours after death.

The funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form

5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death

necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3

to the Chief Medical Examiner's Office along with form

5 may be retained for your files.

Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12871

12350

2a DATE KNOWN Month Day Year
OF ESTI. 913 66 10 PM
DEATH MATED2c DATE PROCLAIMED DEAD
Month 9 Day 13 Year 68 10 PM
2d HOURS7a BIRTHPLACE (State or foreign country) **Virginia** 7b CITIZEN OF WHAT COUNTRY? **U.S.A.** 8 MARRIED NEVER MARRIED
WIDOWED DIVORCED 9 COUNTY OF DEATH **Charles**
10 CITY OR TOWN OF DEATH **La Plata** 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) **Physicians Memorial** 12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) **Teacher** 12b KIND OF BUSINESS OR INDUSTRY **High School**13a JURISDICTION (Where deceased lived, if institution residence before admission) STATE **Md.** 13c CITY OR TOWN **Charles Hughesville** 13d INSIDE CITY LIMITS? YES NO 13e STREET AND NUMBER **Hughesville Manor**14. FATHER'S NAME First Middle Last 15. MOTHER'S MAIDEN NAME First Middle Last **Lonnie Lee Kisher son Roxie Virginia Beall**16a WAS DECEASED EVER IN U.S. ARMED FORCES? **No** 16b SOCIAL SECURITY NO **7** 17. INFORMANT ADDRESS **Mrs. Betty C. Kisher, Hughesville, Md.**

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Approximate Interval Between Onset and Death
812.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost	9-13-68
(b) DUE TO, OR AS A CONSEQUENCE OF	
(c) DUE TO, OR AS A CONSEQUENCE OF	
Officer of Police suicide	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION **9-13-68** 19b CONDITION FOR WHICH OPERATION WAS PERFORMED **Automobile accident** 20 AUTOPSY? YES NO 21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH **Head on auto accident** 21b TIME OF INJURY Month, Day Year HOUR AM PM **9-13-68** 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) **Head on auto accident**21d INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK **At work** 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) **At work** 21f LOCATION Street or R.F.D. No. City or Town County State **Hughesville, Chas., Md.**22a I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from Natural causes , Accident , Suicide , Homicide , Undetermined manner 22b DATE SIGNED **9-14-68**ACTUAL SIGNATURE **Edward J. Edelen** M.D. CHIEF MEDICAL EXAMINER
EXAMINER'S NAME (Type) **Edward J. Edelen** M.D. ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER ADDRESS (Street, city, town, or county)23a BURIAL CREMATION, REMOVAL (Specify) **Burial** 23b DATE **Sept. 17, 1968** 23c NAME OF CEMETERY OR CREMATORIAL **Old Fields** 23d LOCATION (City or Town) (County) (State) **Hughesville, Chas., Md.**24 FUNERAL DIRECTOR ADDRESS **The Hunt Funeral Home, St. Pauls, Md.** 25a REC'D BY REGISTRAR DATE **SEP 20 1968** 25b REGISTRAR'S SIGNATURE **Charles Judge**

MARYLAND STATE DEPARTMENT OF HEALTH

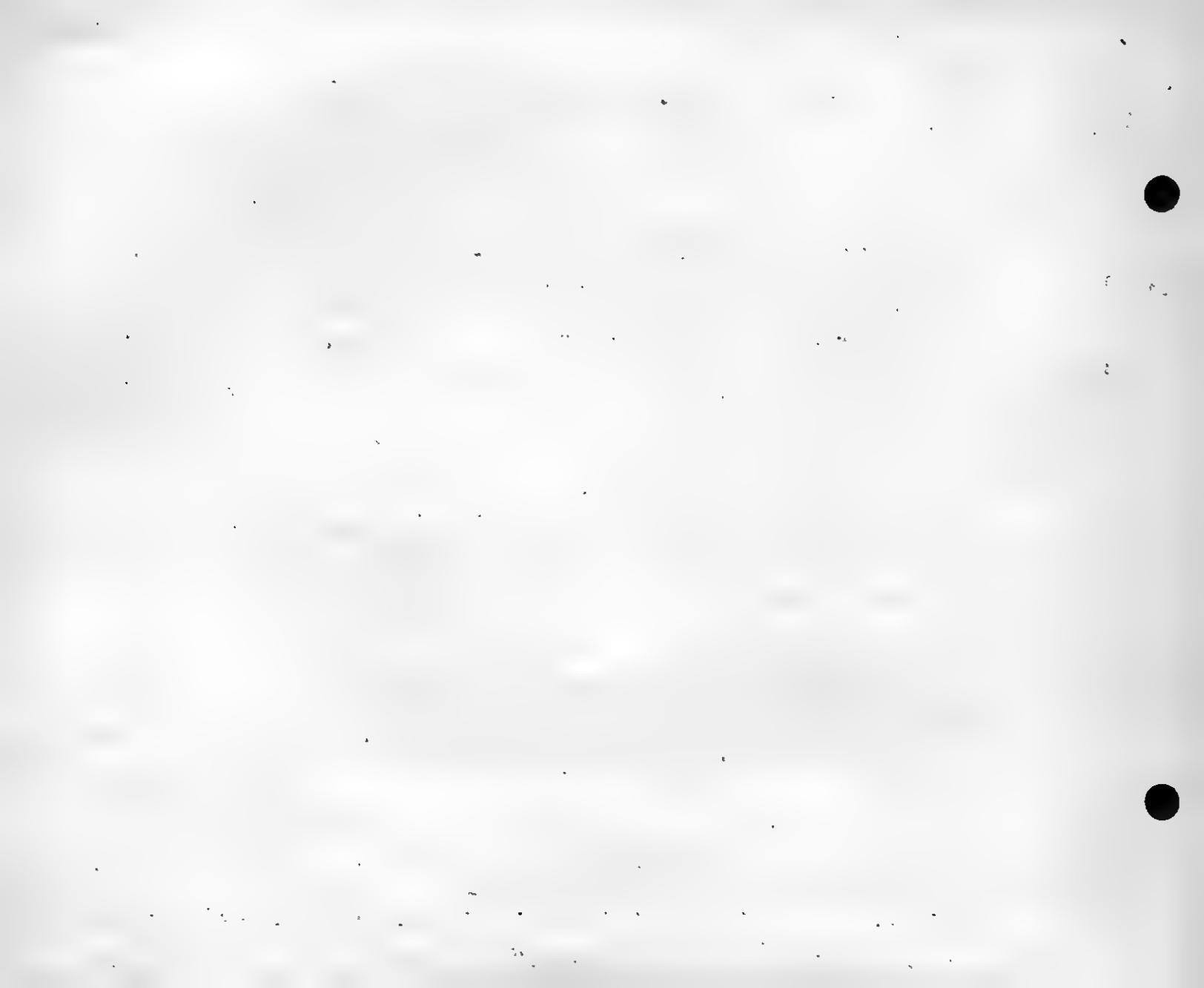
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12872

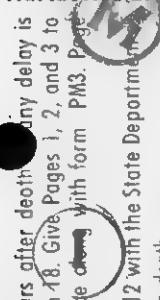
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First LONNIE	Middle LEE	Lost KISNER SR.	2d. DATE OF DEATH Month Sept Day 17 Year 1968	2b. HOUR 11 A.M.
3. SEX MALE	4. RACE CAU.	5. DATE OF BIRTH AUG 18, 1898		6. AGE (in years last birthday) 70 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CHARLES	
10. CITY OR TOWN OF DEATH LA PLATA	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) PHYSICIANS Mem. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret'd.) INSPECTOR	12b. KIND OF BUSINESS OR INDUSTRY SAWMILL
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY CHARLES	13c. CITY OR TOWN LA PLATA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER NONE	
14. FATHER'S NAME First HIRAM	Middle KISNER	Lost FLORENCE	15. MOTHER'S MAIDEN NAME First Middle MOYER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO. (If give war or dates of service) 225-01-5832	17. INFORMANT Roxie Kisner, LA PLATA, MD.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive infarct +100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			30 min.		
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure			1 year.		
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Cardio. vascular disease			3 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 1968 to Sept 1968 , that (I) (we) last saw the deceased alive on 17 Sept 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Arthur O. Woody, MD	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 17 Sept 68	
22d. PHYSICIAN'S NAME (Type) ARTHUR O. WOODY, MD	22e. ADDRESS LA PLATA, MARYLAND, 20646				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-19-68	23c. NAME OF CEMETERY OR CREMATORIAL Trinity Mem. GARDEUS	23d. LOCATION (City or Town) WALDORF, CHARLES, MD.	(County) CHARLES	(State) MD.
24. FUNERAL DIRECTOR HUNT FUNERAL HOME	ADDRESS WALDORF, MD.	25a. REC'D BY REGISTRAR SEP 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12862

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12873

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b. HOUR
JOE SEPH			ALBERT	KNOTT		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sept.	30,	1968	9:00
3 SEX	4. RACE	S. DATE OF BIRTH	6 AGE (in years last birthday)	7 MONTHS	8 DAYS	9 HOURS	MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male	White	MARCH 19, 1905	63 YRS.					Month	Day	Year	A	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		Charles		
MARYLAND		U.S.A.				<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED						
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
LA PLATA			LaPlata Jail			FARMER			TOBACCO			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland			Charles		Hughesville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
JAMES			HENRY	KNOTT		GEORGIANA					DAVIS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT			ADDRESS			
NO			57824-5676			WILLIAM H. KNOTT, HUGHESVILLE, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Metamorphosis of Liver APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
718 Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5810												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22o. I certify that I took charge of the remains described above, held on <u>Autopsy <input checked="" type="checkbox"/></u> , <u>Inspection <input type="checkbox"/></u> , <u>Inquiry <input type="checkbox"/></u> , and in my opinion death resulted from: <u>Natural causes <input checked="" type="checkbox"/></u> , <u>Accident <input type="checkbox"/></u> , <u>Suicide <input type="checkbox"/></u> , <u>Homicide <input type="checkbox"/></u> , <u>Undetermined manner <input type="checkbox"/></u>												
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i>			EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED September 30, 1968			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE 10 2-68			23c. NAME OF CEMETERY OR CREMATORIAL ALL FAITHS Cem.			23d. LOCATION (City or Town) MECHANICSVILLE, MD. (County) (State)			
BURIAL												
24. FUNERAL DIRECTOR			ADDRESS HUNTR FUNERAL HOME, WALDORF, MD.			25a. REC'D BY REGISTRAR DATE OCT 3 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



12863 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12874

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First <i>BABY Jodie</i>	Middle <i>GIRL</i>	Last <i>Lyn</i>	2a DATE KNOWN Month Day Year	2b HOUR of EST- DEATH MATED		
3 SEX Female	4. RACE White	5 DATE OF BIRTH <i>Sept 12, 1968</i>	6 AGE (In years last birthday) — yrs	F UNDER 1 YEAR MONTHS 1	IF UNDER 24 HRS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR 7:30P	
7a BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <i>Charles</i>			
10. CITY OR TOWN OF DEATH <i>Laplate</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>LaPlata Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of work life even if retired.) <i>None</i>		12b KIND OF BUSINESS OR INDUSTRY <i>None</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Charles</i>	13c. CITY OR TOWN <i>Indian Head</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>410 Wood Place 1416nwood</i>			
14. FATHER'S NAME <i>Bernard Edward Lewis</i>		First <i>Bernard</i>	Middle <i>Edward</i>	Last <i>Lewis</i>	15 MOTHER'S MAIDEN NAME <i>Dora Agnes Jones</i>	First <i>Bernard E</i>	Middle <i>Agnes</i>	Last <i>Jones</i>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO. <i>—</i>		17 INFORMANT <i>Bernard E Lewis, Indian Head</i>	ADDRESS <i>1416nwood Pt Indian Head</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART 1. DEATH WAS CAUSED BY</p> <p>IMMEDIATE CAUSE (a) <i>Perinatal pneumonia</i></p> <p>486X</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>(b) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p>								
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>19a. DATE OF OPERATION</p> <p>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</p> <p>20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
<p>22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Ronald N. Kornblum</i></p> <p>EXAMINER'S NAME (Type) <i>Ronald N. Kornblum, M.D.</i></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p> <p>22b DATE SIGNED <i>Sept. 13, 1968</i></p> <p>ADDRESS (Street, city, town, or county)</p>								
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <i>Sept. 14, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Trinity Memorial Gardens</i>		23d. LOCATION (City or Town) (County) <i>Walldorf, Md.</i> (State)		
24. FUNERAL DIRECTOR <i>Hunt Funeral Home, Walldorf, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>SEP 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



12864

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item#5, Film#G4 9/11/68 km

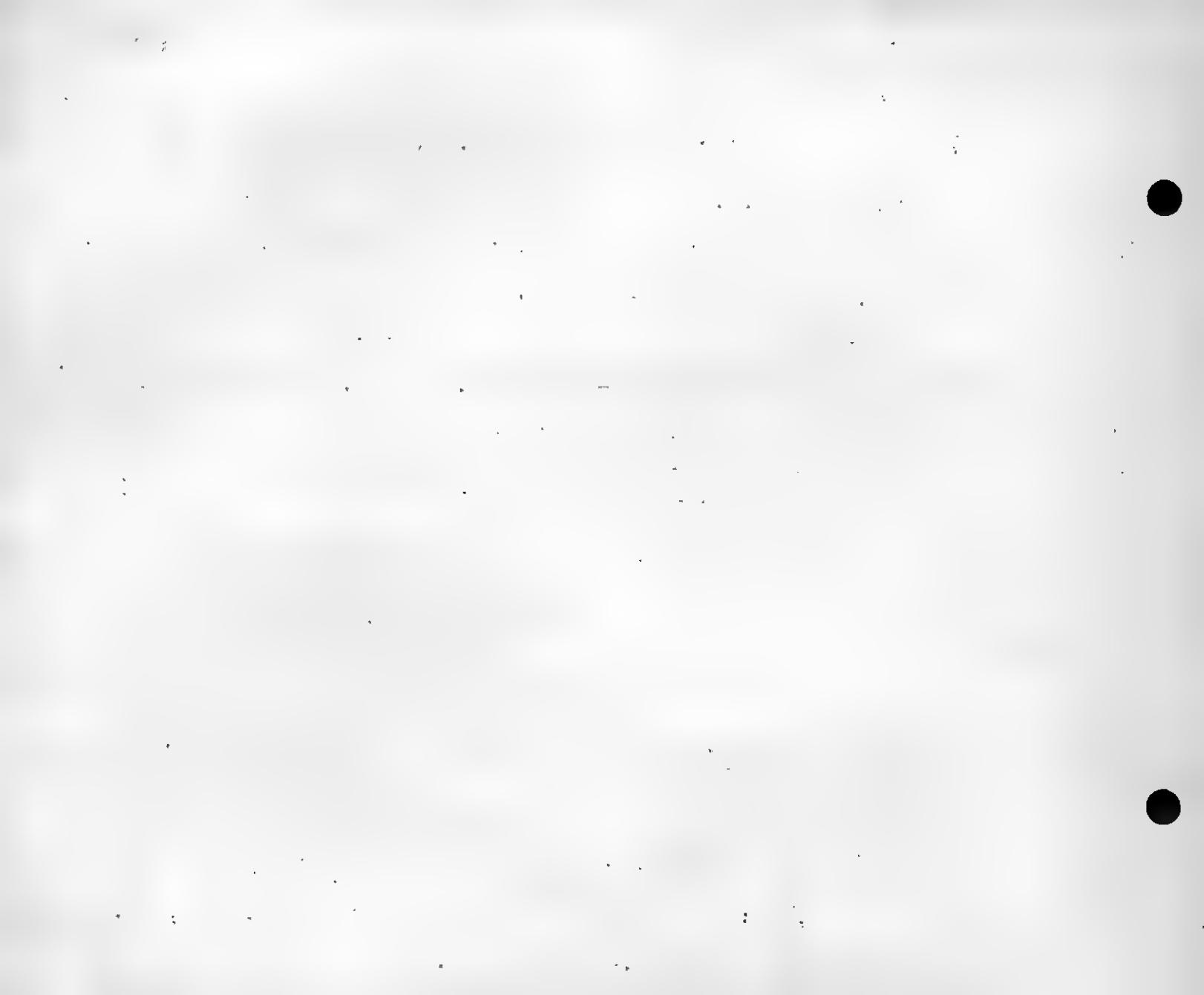
CERTIFICATE OF DEATH

12875/5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>MARTHA</i>	Middle	Last <i>NEAL</i>	2a. DATE OF DEATH Month Day <i>September 3</i>	2b. HOUR Year YRS. <i>1968 12 PM</i>
3 SEX <i>F</i>	4 RACE <i>Negro</i>	5 DATE OF BIRTH <i>Aug. 25, 1886</i>		6 AGE (in years last birthday) <i>82</i>	F. UNDER 1 YEAR MONTHS DAYS HOURS M.N.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Charles</i>		
10. CITY OR TOWN OF DEATH <i>La Plata</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Physicians Memorial</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>House Wife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>Md.</i>	lived, if institution Residence before 13b. COUNTY <i>Charles</i>	13c. CITY OR TOWN <i>La Plata</i>	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First <i>Unkown</i>	Middle	Last	15. MOTHER'S MAIDEN NAME First <i>Unkown</i>	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <i>578-44-0517</i>	17. INFORMANT <i>Mrs. Mary E. Burnett-Daughter</i>	Address Plata, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 min</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>9/2</i> , 19 <i>68</i> , to <i>9/31</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9/21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.					
22b. SIGNATURE <i>Wooddy</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Sept 68</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>ARTHUR O. WOODDY, MD</i> <i>LA PLATA, MARYLAND 20646</i>			
23a. BURIAL, CREMATION, REMAVAL (Specify) <i>Burial</i>		23b. DATE <i>9/6/1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Sacred Heart Cemetery</i>	23d. LOCATION (City or Town) <i>La Plata, Md.</i>	(County) <i>Md.</i> (State)
24. FUNERAL DIRECTOR <i>Arehart Funeral Home, Inc. - La Plata, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>SEP 6 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12876

12865

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send 2 copies to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First JAMES	Middle HENRY	Last PICKERAL	2a DATE OF DEATH Month 9	Day 13	Year 68	2b HOUR 3-40 A.M.
3. SEX M	4. RACE White	5. DATE OF BIRTH July 26, 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH CHARLES				
10. CITY OR TOWN OF DEATH LA PLATA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PHYSICIANS MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY GROCERY STORE		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD	13b. COUNTY CHARLES	13c. CITY OR TOWN WALDORF	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER RT. 2 Box 141			
14. FATHER'S NAME James	First Reese	Middle PICKERAL	Last	15. MOTHER'S MAIDEN NAME FRANCES VIRGINIA WILLETT	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 220-32-6326	17. INFORMANT A. MRS. ELSIE MAY PICKERAL-WALDORF	Address MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 1124							
(b) Arteriosclerotic Heart Disease.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Severe Anemia.							
19a. DATE OF OPERATION -	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/7/1968 , to 9/13/1968 , that (I) (we) last saw the deceased alive on 9/12/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Niranjan Bhaduri, M.D.	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/13/68.		
22d. PHYSICIAN'S NAME (Type) Niranjan Bhaduri	22e. ADDRESS WALDORF, MD 20601						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Sept. 16, 1968	23c. NAME OF CEMETERY OR CREMATORIUM OAKLAND	23d. LOCATION (City or Town) WALDORF Charles MD		(County) (State)		
24. FUNERAL DIRECTOR Hunt Funeral Home Waldorf, Md.	ADDRESS Waldorf Charles	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge				



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12866 Items 1 & 15, Inform. MARYLAND STATE DEPARTMENT OF HEALTH
taken from DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

Birth certif. 10/8/68 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12877

DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATEL	Month	Day	Year	2b. HOUR p. m.	
3. SEX	4 RACE	S. DATE OF BIRTH	6. AGE (in years last birthday) — yrs	IF UNDER 1 YEAR MONTHS 21	IF UNDER 24 HRS DAYS 13	HOURS MIN	9/30	1968	1:00 p. m.	
female	Negro	7/17/1968								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7c. COUNTY OF DEATH Charles			
7d. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Waldorf, Maryland				
14. FATHER'S NAME A Martin		First	Middle	Last	15. MOTHER'S MAIDEN NAME Harrillie Pickeral					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mother - Waldorf, Md.	ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Interstitial Pneumonitis (SDII)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Werner U. Spitz</u>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/1/68		
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE Oct. 2, 1968		23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Ch. Cemetery		23d. LOCATION (City or Town) Waldorf, P. O. Box, Md.		(County) (State)		
24. FUNERAL DIRECTOR <u>Martell Caskets Aquasco, Md.</u>		ADDRESS		25a. RECD BY REGISTRAR OCT 3 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12878

CERTIFICATE OF DEATH

12867

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. In any event, within 72 hours after death, this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. DECEASED NAME (Type or print)		First Baby	Middle Girl	Lost PROCTOR	2a. DATE OF DEATH Month Sept Day 20 Year 68	2b. HOUR 135 M	
3. SEX Female		4 RACE Negro	5. DATE OF BIRTH September 20, 1968		6. AGE (in years at first birthday) — YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF JUNIOR 24 MRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Charles, Md. U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Charles		
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done or position in working life, even if retired) Hospital None		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Charles	13c. CITY OR TOWN Pisgah	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
14. FATHER'S NAME First JAMES		Middle SMITH	Lost Proctor	15. MOTHER'S MAIDEN NAME First Lourina	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mr. James Smith-Father-	Address 311 Naylor Rd. Wash., D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) New birth wt.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours.			
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c), failure of lungs to expand profately							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 16.00							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 9-20, 1968 , to 19-1 , that (I) (we) last saw the deceased alive on 9-20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Johnson		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-22-68			
22d. PHYSICIAN'S NAME (Type) J. M. Johnson		22e. ADDRESS La Plata, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/23/1968	23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's Cemetery		23d. LOCATION (City or Town) Pomfret, Maryland	(County)	(State)
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. - La Plata, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE SEP 26 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Page 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

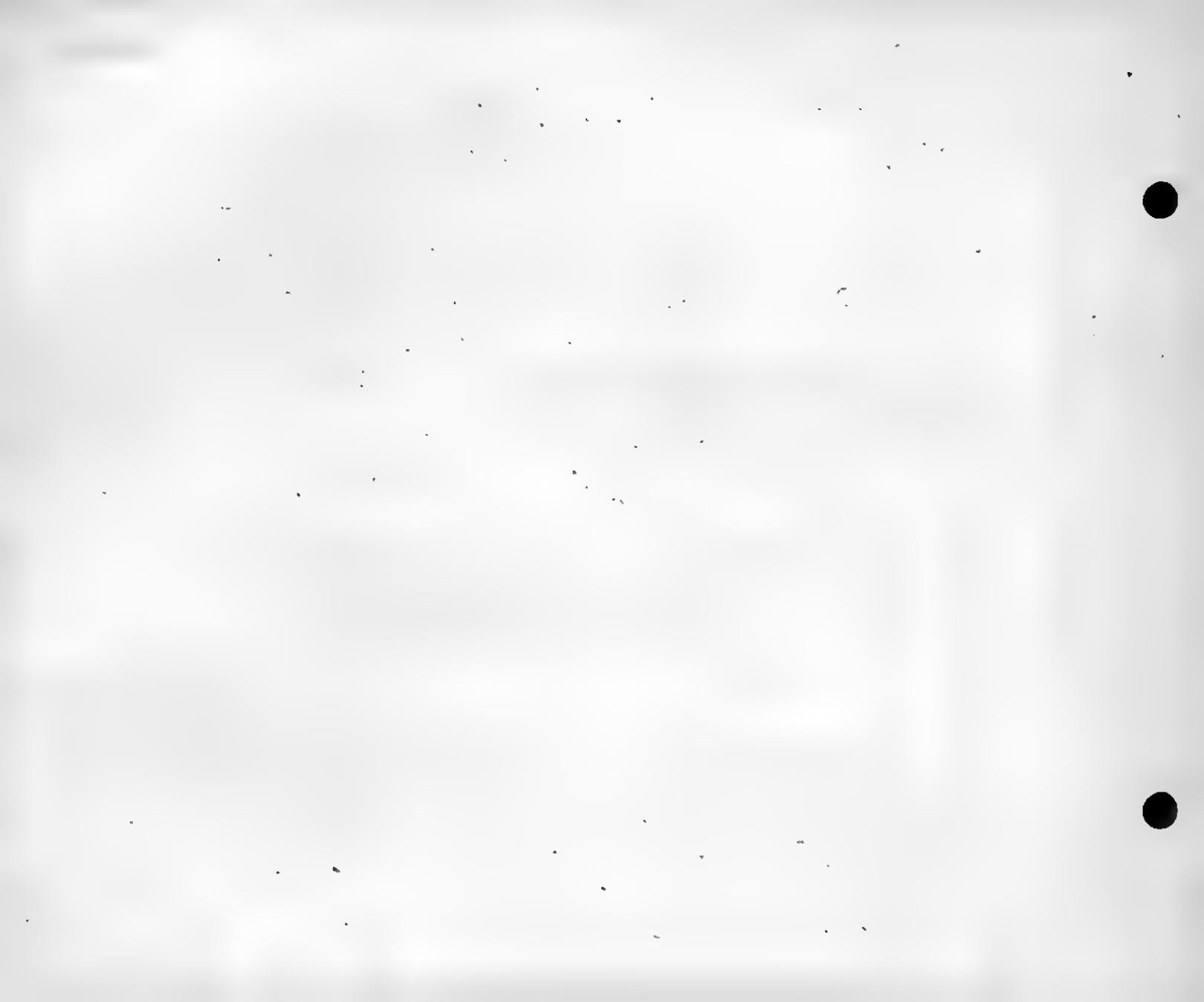
12868

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12879

1 DECEASED NAME (Type or print)	First <i>PATRICK FRANCIS ROWAN</i>	Middle <i></i>	Last <i></i>	2a. DATE OF DEATH Month <i>9</i>	Day <i>25</i>	Year <i>68</i>	2b. HOUR <i></i>						
3 SEX <i>Male</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>Nov 15, 1887</i>	6. AGE (in years last birthday) <i>90</i>	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS DAYS <i></i>	HOURS <i></i>	MIN <i></i>						
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Charles</i>										
10. CITY OR TOWN OF DEATH <i>Lafayette</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital or at street address) <i>Physicians Memorial Hospital</i>	12a. USUAL OCCUPATION (Kind of work done or not doing work in life, even if retired.) <i>Electrical Gen. Motors</i>	12b. KIND OF BUSINESS OR INDUSTRY <i></i>										
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>Charles</i>	13c. CITY OR TOWN <i>White Plains</i>	13d. INSIDE CITY LIMITS? <i>YES</i>	13e. STREET AND NUMBER <i>White Plains, N.Y.</i>									
14. FATHER'S NAME First <i>Michael</i>	Middle <i>Rowan</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Katherine</i>	Lost <i></i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>44-09-5894A</i>	17 INFORMANT <i>John P. Rowan</i>	Address <i>White Plains, N.Y.</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Car accident</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9-22-68</i>					
+ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i></i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diseases</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i></i>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED <i>9-26-68</i>					
22b. SIGNATURE <i>J. E. DeLeon</i>								DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) <i>J. E. DeLeon</i>								22e. ADDRESS <i>Lafayette Md</i>					
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial 19-30 1968</i>	23b. DATE <i>Vincent's</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i></i>	23d. LOCATION (City or Town) <i>Marksville</i>	(County) <i>Pa.</i>	(State) <i>Pa.</i>								
24. FUNERAL DIRECTOR <i>Hurst Funeral Home Waldorf, Md.</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR DATE <i>SEP 27 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>										



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12880

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please engrave carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, after any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR 5:30 A.M.
James Bowie Shelton			9-20-68		
3 SEX	4. RACE	S DATE OF BIRTH	6 AGE (in years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White U.S.	April-26-1899			
7a BIRTHPLACE (State or foreign country) Virginia	7b CITIZEN OF WHAT COUNTRY? USA.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Charles County		
10 CITY OR TOWN OF DEATH LaPlata Md	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) physicians Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY US-Govt.
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b COUNTY Charles	13c CITY OR TOWN Indian Head	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 1002 Straus Avenue	
14. FATHER'S NAME First James W. Shelton	Middle	Last	15 MOTHER'S MAIDEN NAME First Middle Last (Unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b SOCIAL SECURITY NO 223-14-2148	17 INFORMANT Wife-Ann W. Shelton-Indian Head Md.	Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Gastro-Enteritis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8-Days		
DUE TO, OR AS A CONSEQUENCE OF (b) Influenza - Gastro-intestinal			8-Days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 48					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cirrhosis Liver					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a I certify that (I) <input type="checkbox"/> attended the deceased from 9-15-68, 19 <input type="checkbox"/> , to 9-20-68, 19 <input type="checkbox"/> , that (I) <input type="checkbox"/> lost saw the deceased alive on 9-20-68, 19 <input type="checkbox"/> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"> (they) <input type="checkbox"/> view the body after death.</input>					
22b. SIGNATURE <i>James E. Andrews MD</i>	ATTENDING DEGREE PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9-20-68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Indian Head Md.				
23a. BURIAL, CREMATION, (Check one or both) Burial	23b. DATE 9/23/1968	23c. NAME OF CEMETERY OR CREMATORIUM Nazeringe Cemetery	23d. LOCATION (City or Town) Pisgah, Maryland	(County)	(State)
24 FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.	ADDRESS	25a. RECD BY REGISTRAR DATE SEP 24 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VII A 152 30M REV 1/68					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

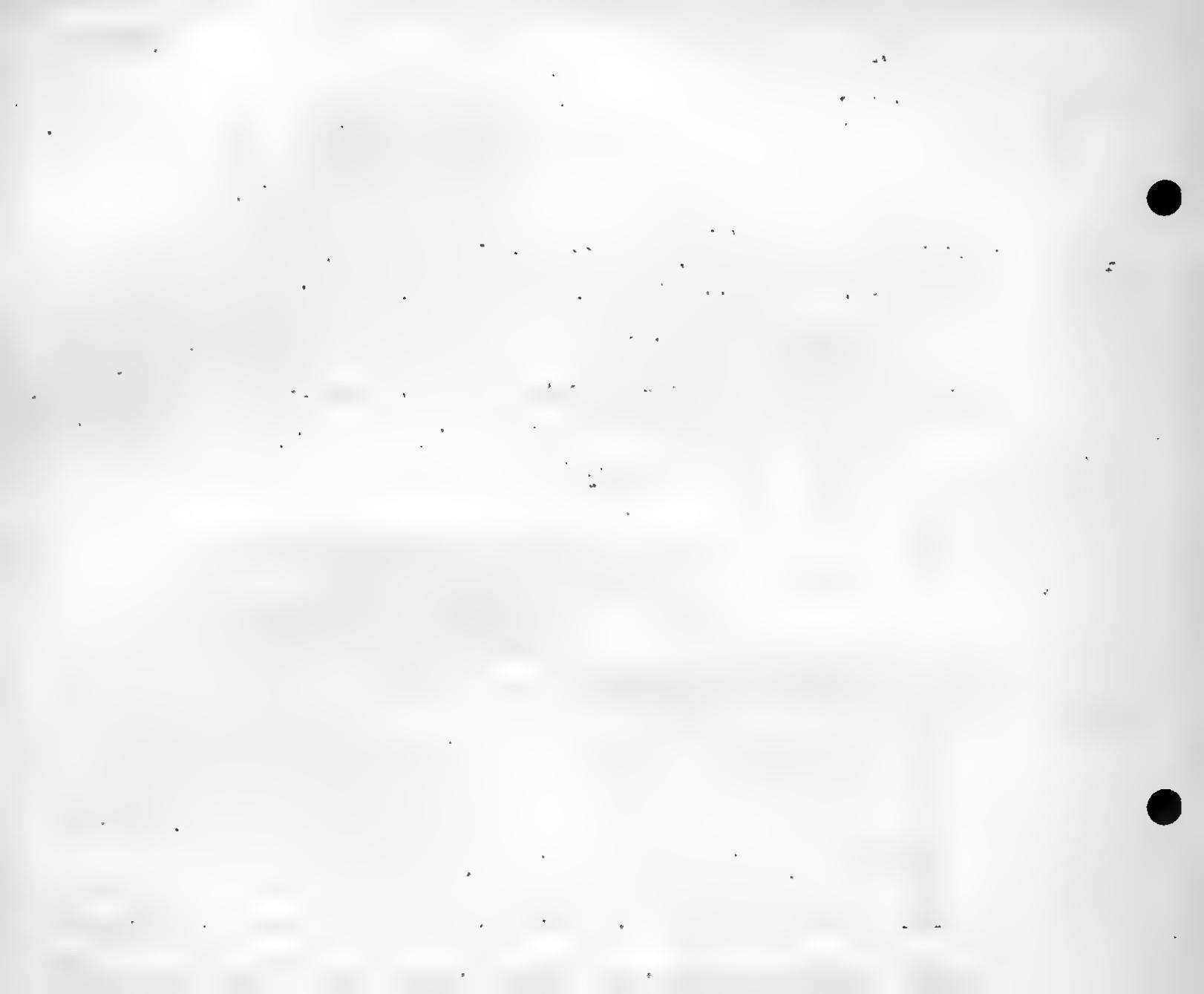
CERTIFICATE OF DEATH

12881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Beth HA</i>	Middle <i>Stoger</i>	Lost	2a. DATE OF DEATH Month <i>9</i>	2b. HOUR <i>9:48 AM</i>
3. SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>1-16-93</i>	6 AGE (In years last birthday) <i>78 yrs.</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 1 HRS HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>HUNGARY</i>	7b. CITIZEN OF WHAT COUNTRY? <i>Hungary</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Charles</i>		
10. CITY OR TOWN OF DEATH <i>La Plata</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>New Stogar</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House Wife</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md.</i>	13b. COUNT <i>Charles</i>	13c. CITY OR TOWN <i>Potomac Hgts.</i>	13d. INSIDE CITY LIMITS? <i>NO</i>	13e. STREET AND NUMBER <i>18 Delta Place</i>	
14. FATHER'S NAME First <i>(Unknown)</i>	Middle <i>Sieler</i>	15. MOTHER'S MAIDEN NAME First <i>(Unknown)</i>	Middle <i></i>	Lost <i></i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>081-20-2644</i>	17. INFORMANT <i>Louis P. Stoger-Son</i>	41 Cypress Place	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8-10-60</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i> (b) <i>HYPERTENSION</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost (c) <i></i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>44.3x</i>					
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> Yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <i>8-18-68</i> , to <i>9-2-68</i> , that (I) (we) last saw the deceased alive on <i>9-2-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>E. J. DeLeen</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>9/4/1968</i>
22d. PHYSICIAN'S NAME (Type) <i>E. J. DeLeen</i>		22e. ADDRESS <i>La Plata, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9/7/1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Charles Cemetery</i>	23d. LOCATION (City or Town) <i>Glymont</i>	(County) <i>Maryland</i>	(State)
24. FUNERAL DIRECTOR <i>Arehart Funeral Home, Inc. - La Plata, Md.</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i>SEP 6 1968</i>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		



FOR STATE
HEALTH DEPT.

MARYLAND
DEPARTMENT OF
HEALTH

12872
Page 2
of 2
to file with the State Department

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMT. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used of a burial-transit permit. File pages 1 and 2 with the State Department. Remove and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12882

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	2b HOUR 11:30 A. M					
LYNN				THOMAS				9/26 68					
3 SEX	4 RACE	S. DATE OF BIRTH	6 AGE (in years at birthday)	7 IF UNDER 1 YEAR	8 IF UNDER 24 HRS	9 MONTHS	10 DAYS	11 HOURS	12 MIN.	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR 11:30 A. M		
male	negro	12-22-18	49 yrs							September 26, 1968			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Charles			
WARENTON VA.		U.S.A.										Md	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
CHARLES County		LaPlata Hospital				LABORER				CONSTRUCTION			
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS <input type="checkbox"/>		13e. STREET AND NUMBER					
D.C.				Washington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2709 Bruce Pl., S.E.					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last				
ANTHONY THOMAS					JEAN EATON								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO				JEAN EATON									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Multiple Injuries													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
19c. MEDICAL CERTIFICATION													
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:45 AM 9/26/19 68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				Subj.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) ditch		21f LOCATION Street or R.F.D. No		City or Town		County		State			
										Charles, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Werner U. Spitz, M.D.				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/27/68			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>													
ADDRESS (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10/2/68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Washington D.C.		23d. LOCATION (City or Town) WARENTON VA.		(County)		(State)			
24. FUNERAL DIRECTOR						25a. RECD BY REGISTRAR DATE SEP 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					
W.H. Bacon 3447 14th St NW													



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12884

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First: <u>GLEN</u>	Middle: <u>WALTER</u>	Last: <u>YARNADO</u>	2d. DATE OF DEATH Month: <u>May</u>	Day: <u>10</u>	Year: <u>1968</u>	2b. HOUR AM.				
3. SEX <u>Male</u>		4. RACE <u>White</u>		S. DATE OF BIRTH <u>May 9, 1905</u>	6. AGE (in years last birthday) <u>63</u>		YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Charles</u>							
10. CITY OR TOWN OF DEATH <u>La Plata</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Physicians Mem. Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Painter</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Charles</u>		13c. CITY OR TOWN <u>Indiana Head</u>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>44 Mattingley Avenue</u>						
14. FATHER'S NAME First <u>Walter Scott</u>		Middle <u></u>	Last <u>Varnado</u>	15. MOTHER'S MAIDEN NAME First <u>Lela</u>		Middle <u></u>	Last <u>Farrell</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>425-12-2271</u>		17. INFORMANT <u>Mrs. Lucille Varnado-Wife</u>		Address <u>Indian Head, Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2001</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>2001</u>												
19a. DATE OF OPERATION <u>2001</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-5</u> , 19 <u>68</u> , to <u>7-8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>E.J. Edelen</u>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>9/8/1968</u>						
22d. PHYSICIAN'S NAME (Type) <u>E.J. Edelen, M.D.</u>		22e. ADDRESS <u>La Plata, Maryland</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/1/1968</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Osyke Cemetery</u>		23d. LOCATION (City or Town) <u>Osyke</u>		(County) <u>Mississippi</u>	(State)				
24. FUNERAL DIRECTOR <u>Nartman Funeral Home - McComb, Miss.</u>		25a. REC'D BY REGISTRAR <u>DA SEP 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								
Arehart Funeral Home, Inc. - La Plata, Md.												

2021

FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12872

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12883

1. DECEASED-NAME (Type or Print)	First HUGH	Middle R.	Last Wilmer	2a. DATE KNOWN OF ESTI- DEATH MATED	Month 9	Day 23	Year 1968	2b. HOUR 10 AM						
3. SEX M	4. RACE W	S. DATE OF BIRTH 7-28-97	6. AGE (in years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month 9	Day 23	Year 1968	2d. HOUR 4 PM				
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Charles											
10. CITY OR TOWN OF DEATH Hughesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13c. CITY OR TOWN Charles	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Hughesville											
14. FATHER'S NAME First PERE	Middle WILMER	Last	15. MOTHER'S MAIDEN NAME First AMELIA	Middle	Last MATTHEWS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) Yes	16b. SOCIAL SECURITY NO. WW 1	16c. INFORMANT 212-52-2980 Mr. Joseph A. Wilmer-Son/Schiller, Pk.	10130 Iwanhoe Court											
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rushed Chest & Internal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Working under jacked up car which fell on him DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-23-68					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9100														
19a. DATE OF OPERATION 9/20	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. TIME OF INJURY Month, Day, Year 10 29 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) CAR fell on him												
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home - Farm	21f. LOCATION Street or R.F.D. No. Hughesville MD CHAS	City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									22b. DATE SIGNED 9-23-68					
ACTUAL SIGNATURE <i>E. J. Edelen</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>													
EXAMINER'S NAME (Type) E. J. Edelen	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>													
23a. BURIAL, CREMATION, REMOVAL Burial									23c. NAME OF CEMETERY OR CREMATORIAL Mt. Rest Cemetery			23d. LOCATION (City or Town) La Plata, Maryland		
23b. DATE 9/26/1968	ADDRESS			25a. REC'D BY REGISTRAR DATE SEP 26 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.														

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